LEGAL DUTIES INVOLVING PHYSICIANS, PATIENTS AND THIRD PARTIES

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Part One

INTRODUCTION

At the risk of oversimplification, it can be said that physicians view people as comprising two groups: patients and all others. Although informed consent and malpractice litigation have heightened physicians' awareness of the legal aspects of their relationships with patients, they may be unaware that they owe legal duties to non-patients as well. To complicate matters, duties owed to third parties can conflict with those owed patients. The doctor-patient relationship, for example, is clothed with confidentiality, privacy, and trust. How can a physician fulfill a duty to maintain patient confidentiality when faced with a contrary duty to warn a non-patient of danger posed by the patient?

This article is the first of two designed to familiarize physicians with certain legal duties owed non-patients who are endangered by either the medical conditions or treatments of patients. Part One provides a context for the subject and relates how the law viewed physicians' duties to third parties prior to a seminal California case, *Tarasoff v. the Regents of the University of California*, that shook the foundation of precedent.[1] Part Two will discuss the duty "discovered" in *Tarasoff* and subsequent developments. Certain terms that have specific meaning in the law will be briefly explained when first encountered in the text, to the extent that the law has clearly defined them.

BACKGROUND

A legal **duty** is an obligation to a specific person, group or society at large, that is legally enforceable. In the absence of contract, when a duty is breached (violated, not met, improperly met) resulting in injury to a party to whom the duty is owed, a **tort** is said to have occurred. To be more precise, the breach must have been both the actual cause as well as the **proximate cause** of the injury. The concept of proximate cause is difficult for many judges and attorneys, let alone physicians, to articulate and understand. The proximate cause of an injury has been defined as "the primary or moving cause, or that which, in a natural and continuous sequence ... produces the injury and without which the accident could not have happened, if the injury be one which might be **reasonably** anticipated or **foreseen** as a natural consequence of the wrongful act."[2]

Reasonably foreseeable reflects the law's attempt to view human events through the eyes of a reasonable, average and objective person. Outlandish theories or fanciful speculation about foreseeability, and the mere possibility that an event might occur are not reasonable, although they may be tempting explanations when events are viewed in retrospect. The injury or outcome of substandard behavior must have been predictable without undue effort. This does not mean that the exact injury suffered need be foreseen. Only a general appreciation that injury itself could occur is required.

A court should declare that there can be no duty to avoid a harm if that harm is not foreseeable. Courts should also find that a breach was not the proximate cause of an injury that could not have been reasonably foreseen, even though the breach might have been a cause-in-fact.

As an example, an inattentive motorist hits a pedestrian who is HIV positive. The pedestrian bleeds and contaminates a rescuer. The rescuer, with no risk factors, is found to be HIV positive years later, but not before she has passed the virus to her child who dies from AIDS. The child's estate traces the HIV back to the pedestrian and sues the motorist for causing the child's death. While the motorist's unlawful behavior was a cause-in-fact by setting in motion a causally related chain of events leading to the child's death, it is unlikely that a court would hold the motorist responsible for that injury because the breach was not the proximate cause of the child's death. The foreseeability of the death would not be sufficiently reasonable to sustain liability.

The chain of events between a breached duty and an injury can be broken by events unrelated to the breach. These are called independent, supervening, superseding or intervening events. They change the foreseeable course set in motion by the original breach and cause their own adverse results that cannot be fairly attributed to the original breach.

How do legal duties come about? They arise from constitutions, statutes, regulations, court cases, or case law. Whatever their source, all legal duties are theoretically based on the concept of "public policy", considered to be important by society at large to maintain a safe and orderly environment.

Duties generally reflect relationships among or between people. Persons involved are referred to as "parties", and the basic relationship is between first and second parties. Beyond them lie **third parties**, those persons not directly involved in the legal relationship. In the physician-patient relationship, the physician and patient are first and second parties, and all others are third parties.

Because the doctor-patient relationship is a special relationship in the eyes of society and the law, the duty of care owed a patient is a special or extraordinary duty, that of the reasonable physician. A breach of that duty proximately causing an injury to a patient is referred to as medical negligence or malpractice.

Outside special relationships, all people have a duty to use **ordinary care** to avoid harming others. A common example of this duty involves the driving public. Each driver must use ordinary care to avoid injury to others occasioned by careless use of a motor vehicle. Special relationships entail additional duties, but the general duty is always in force.

Is there a duty to rescue another? The common law has never imposed a general legal duty to rescue or help a person out of trouble, unless the trouble was caused by the potential rescuer. This "no duty" rule applies even if the harm could be easily prevented by the bystander.

Common law has also held that no one has an affirmative duty to control the actions of another, absent a special relationship. A parent, for instance, is legally obligated to protect his child from injury by another of his children. In a medical context, a physician has a duty to control his violent psychiatric inpatient to prevent injury to another inpatient under his care.

Case law from a variety of jurisdictions has held physicians responsible for controlling the behavior of their patients if the "special relationship" requirement is met by the existence of: a doctor-patient relationship, a special relationship a physician may have with an injured third party, or a special relationship a patient may have with an injured third party.

The legal duty of a physician to prevent harm to third parties when that harm can foreseeably result from the medical condition or treatment of a patient has been created primarily by case law. Cases involve discrete facts, often of a unique nature. They are resolved by applying general principles of law to the specific factual situation. When established principles do not seem readily applicable to the facts of a case, however, courts may create law through reasoning by analogy, modifying general legal principles, looking to the law of other jurisdictions, interpreting statutory law in a particular way to fit the case, or deciding that public policy demands a new approach.

All those techniques have been applied to cases involving physicians' duties to non-patients. One should, therefore, pay particular attention to the facts of a case because cases that appear similar may prove quite different when the legal issues and the relationships of the parties are carefully scrutinized.

Two other points deserve mention. First, duties to more than one party may conflict. The single greatest tension in cases regarding physicians' duties to non-patients has been between the simultaneous obligations of protecting third parties and maintaining patient confidentiality. Courts have resolved this conflict in both directions, holding that

one duty is less important and must yield to the other. Second, much of the law concerning duties to non-patients is derived from appellate court decisions involving cases that were dismissed by lower courts without a trial on the merits. An appellate court answers only one question: if the facts as pleaded to the lower court are assumed to be true, does the injured party have a "cause of action"? That is, does the plaintiff evidence the right to a societally-valued interest, such as personal health and safety, that the law recognizes as worthy of protection, and thus imposes a duty on another? If the answer is yes, the case is remanded to the lower court for complete litigation, where the facts, as pleaded by the plaintiff, may or may not be proven.

After an appellate court determines that the plaintiff has a cause of action or that a jury could reasonably find in favor of the plaintiff under the alleged facts, an out-of-court settlement often ensues. Cases resolved through a full trial are not uniformly successful for the plaintiff, especially ones involving a physician's duty to non-patients.

PRE-TARASOFF DANGERS

What has the law recognized as dangers posed to third parties by patients, from which non-patients have a right to be protected? Where does the physician stand, and what is legally expected of him?

Prior to 1976, when *Tarasoff* was finally decided, cases involving physician obligations to third parties were infrequent. Most fell into two categories. Patients were dangerous to others either because they suffered infectious diseases ("disease cases") or because their ability to drive safely was impaired by their physical condition or prescribed medications ("driving cases").

In a 1919 Minnesota case, the first of its kind to reach a state supreme court, a physician diagnosed scarlet fever in a child and incorrectly advised the parents that they could visit their child in the hospital without fear of becoming infected.[3] The physician later discharged the child during the infectious stage of his illness without advising the parents of any dangers. Both parents contracted scarlet fever and sued for damages. The doctor denied liability. (He had, in fact, committed no malpractice in treating the child.) At trial, the doctor argued that since there was no physician-patient relationship with the parents, as third party non-patients, he owed them no duty.

Emphasizing that the health of citizens is important to the state, the court found that the physician owed a duty of ordinary care to the parents to protect them from "the direct consequences of his negligent acts. . . ." The court also noted that the physician "assumed the obligation to use due care" when advising the parents, even if he did so gratuitously. The duty was non-contractual.

The physician's compliance with the state's contagious disease reporting requirements had not fulfilled his duty to the parents. The most significant legal impediment in the case was the fact that the parents, although injured by the negligence of the physician, could not sue for medical malpractice because they were not patients. The court found a way out of this dilemma by focusing on the rule of ordinary care. An alternative argument by the physician, that it was common knowledge that scarlet fever was contagious, in the court's opinion, did not deprive the parents of a cause of action.

It is important to note that the above case does not involve a duty to warn. The Minnesota court declared that when a physician caring for a patient with a dangerous, contagious disease acts affirmatively and negligently toward a third party, who is injured because of the disease of the primary patient, liability will follow. Comments of the court suggest, however, that the doctor would have been held accountable had he done nothing to warn the parents of the danger of becoming infected. The case recognized a duty to family members that could be applied today under circumstances involving the foreseeable transmission of AIDS from one family member to another, a particularly complex legal issue.[4]

Subsequent cases have involved a variety of patients with dangerous diseases that have injured third parties. In *Davis v. Rodman,* a case involving a patient with typhoid fever, the court held that physicians have an affirmative duty to warn, perhaps protect, family members "and others who are likely to be exposed" to the danger of contagion and to recommend precautions necessary to prevent spread of the disease.[5] The "others" included nurses caring for the patient. Those duties are not discharged by merely following state reporting rules. In *Davis,* as well as in *Skillings,* the patient was a child who could neither take action nor assume personal responsibility for containing the danger of his disease.

In *Jones v. Stanko,* a neighbor of a smallpox patient asked the attending physician if it was safe to care for his friend.[6] Relying on the physician's reassurance, the neighbor attended the patient, later contracted smallpox and died. (Ironically, the neighbor had prepared the original patient's body for burial!) The Supreme Court of Ohio determined that it was the physician's duty to warn anyone in proximity to a smallpox patient of the dangerous nature of the disease. This case is notable not only for the involvement of a third party who was not a family member, but also because the injured third party had specifically asked the doctor about possible danger. Had the physician's act been a passive omission rather than a negligent declaration, a different legal outcome may have resulted.

The facts in the contagious disease cases often suggest that the injured non-patients contracted their diseases before the attending physicians reasonably could have warned them. In the early stages of highly infectious diseases, the diagnosis may not be well established when the disease is its most contagious. The key issue, then, is proximate cause. Nonetheless, courts have found a fundamental duty to non-patients in such cases, and the issue of proximate cause must then be resolved with a trial.

What about the duty of confidentiality? Not all infectious diseases are equally contagious. Syphilis, for example, is more containable than typhoid fever, tuberculosis, or scarlet fever. This question was addressed in one of the earliest cases dealing with confidentiality. In *Simonsen v. Swenson,* the court noted, "No patient can expect that, if his malady is found to be of a dangerously contagious nature, he can still require it to be kept secret from those to whom, if there was no disclosure, such disease would be transmitted."[7] It is interesting that one legal researcher has reported that no physician or hospital sued for failure to warn third parties about the danger of contagious disease has used "confidentiality of medical information" as a defense.[8]

Patients may also be dangerous to third parties when their judgement, behavior, or coordination is adversely affected by a medical condition or its treatment. The law views members of the driving public and pedestrians as reasonably foreseeable potential victims of a patient whose driving ability has been compromised by the carelessness of his physician. Unlike cases involving infectious children who are powerless to act to prevent harm to third parties, the typical "driving case" involves an adult who could, if timely and properly advised, avoid injury to others. Obviously, even if a physician went on television to warn the public that a patient has a prolonged reaction time due to a medication, or is subject to losses of consciousness, or cannot see or hear well, or is too weak to maneuver a vehicle, not every motorist would be reached. Efforts to warn all other drivers and pedestrians would be neither practical nor effective.

A patient, however, may drive while suffering adverse effects of medication about which his physician failed to advise him. Another patient may not have been informed that his disorder is characterized by episodes of loss of consciousness. The first patient's medication may well have been properly prescribed, and the second patient may have been correctly diagnosed. Substandard medical care is not the issue.

The failure of a physician to advise his patients of the dangers their medical conditions or treatments pose to the driving public is considered a violation of the duty of ordinary care owed by the physician to third parties. If the physician properly advises the patient to avoid driving, yet the patient nonetheless decides to "risk it" anyway, then the physician will likely avoid liability. The patient's action then becomes a supervening and independent cause

of any third party injury. But what if a physician knows or should know that the patient will not follow instructions? Does the physician have a duty to control the patient? Unless the patient is mentally ill, the answer is probably no, but there are few published appellate cases on this question.

Kaiser v. Suburban Transportation System is an illustrative "driving case".[9] Kaiser, a bus passenger, was injured when the driver fell asleep and struck a telephone pole. The driver stated that he had been given pyribenzamine by his doctor for a nasal condition but had not been warned about the side effect of drowsiness.

In his argument for dismissal of the case against him, the doctor emphasized that the driver had felt drowsy several minutes before the accident. Being a professional, the driver knew or should have known that driving was dangerous when drowsy and should have stopped the bus before the accident. The driver's act, it was argued, constituted an intervening cause of Kaiser's injury.

The court, however, invoked the legal theory that, even if an intervening act is negligent, it may not constitute a superseding cause of harm if the initial negligent conduct (the physician's failure to warn of side effects) remains a substantial factor in causing the injury. The court added that, if a physician's negligence foreseeably results in injury to a third party, the physician can be held liable.

The standard of care as to what other physicians in the community told patients about the side effects of pyribenzamine became an issue in this case. The court found that it was the physician's duty to issue a warning about the side effect of drowsiness. Should the jury at trial on the case on the merits conclude that the physician had given the warning, he would not be held liable. Should the jury conclude that he did not give the warning, the physician would be liable whether the driver was careless or not. Clearly, the court assumed that the bus driver was a person who, with the proper advice, could and should act to protect others from his dangerousness. The physician's duty was to advise the patient. By so doing, the physician would have met his duty to third parties.

In the next issue of Open File, physicians' liability for dangerous patients will be analyzed, focusing on the behaviorally disordered patient.

REFERENCES

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